



NC Medicaid Provider Enrollment CSC EVC Center

P. O. Box 300020
Raleigh, NC 27622-8020

For certified /overnight mail only:
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073

Dear Organization Provider,

Thank you for your interest in enrolling as a North Carolina Medicaid and as a Primary Care Provider (PCP) with the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) program. In order for us to complete the process, please mail the following documents to CSC:

Complete and sign the following required documents:

- ☐ Organization Provider Enrollment Application with CCNC/CA. The applying Individual Provider must sign and date this application.
- ☐ NC Department Of Health And Human Services (DHHS) Provider Administrative Participation Agreement
- ☐ Letter of Attestation
- ☐ NC Division Of Medical Assistance (DMA) Provider Certification For Signature On File
- ☐ NC DHHS DMA Electronic Claims Submission (ECS) Agreement
- ☐ Substitute W-9 Request for Taxpayer Identification Number and Certification
- ☐ Agreement for Participation as a Primary Care Provider In North Carolina's Patient Access and Coordinated Care Program (Carolina ACCESS)
- ☐ NC DHHS DMA Provider Confidential Information and Security Agreement (optional)
- ☐ Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement (if you do not have hospital admitting privileges)
- ☐ Health Check Agreement between Primary Care Provider (PCP) and the Local Health Department (if you cannot or choose not to perform the comprehensive health check screenings)

You must also provide a current copy of the following:

- ☐ National Plan and Provider Enumeration System (NPPES) letter
- ☐ Licenses, certifications, accreditations, endorsements, etc.
- ☐ Border Providers: Your home state's Medicaid Welcome Letter
- ☐ If you selected Sole Proprietor or Single-Owner LLC: A copy of the applicant's EIN letter from the IRS

Retain a copy of your completed Organization Provider Enrollment Application with CCNC/CA packet and all documentation submitted for your records. You will be notified by mail once the enrollment process has been completed.

Billing information and clinical coverage policies (DMA): <http://www.ncdhhs.gov/dma/provider/>
CCNC/CA for Providers (DMA): <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm>

Thank you again for your interest. If you have any questions or need additional information, please feel free to contact NC Medicaid Provider Enrollment at the CSC EVC Center at 866-844-1113 or email the CSC EVC Center at NCMedicaid@csc.com.



North Carolina Department of Health and Human Services Organization Provider Enrollment Application with CCNC/CA

For assistance completing this application, please call the CSC EVC Center at 866-844-1113

Organization Information

Organization Name – as shown on income tax return *

NPI *	Employer Identification Number (EIN) *
	-
Month of Fiscal Year End *	Do you operate under a trade or company name, (i.e., Acme Health Care Inc doing business as (DBA) Community Family Practice? *
	Yes No

Doing Business As (DBA) information

DBA Name	
NC Secretary of State ID #	Years Doing Business Under This Name

Former Doing Business As (DBA) information

Have you used a different DBA Name?	Former NC Secretary of State ID#
Yes No	
Former Doing Business As (DBA) Name	

Effective Date and Provider Number

Effective Date Requested (MM/DD/CCYY)	Note: The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment shall not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received by the CSC EVC Center and shall not precede applicable licensure/accreditation/certification/endorsement documents that are required for enrollment.
/ /	
Have you previously been enrolled as a provider with the Division of Medical Assistance? *	If yes, what is your NC DHHS Provider Number?
Yes No	

Change of Ownership/Merger/Acquisition

Is this application in conjunction with a change of ownership, stock purchase, change in a shareholder's/partner's percentage of interest in ownership, transfer of title, or a merger? *	Date of ownership change:	NC DHHS Number Assigned to Previous Owners(s)
Yes No	/ /	

Taxonomy Codes

Please enter all the taxonomy codes that are registered with your NPI.

*			

Provider Type (Please select only one)

Independent Practitioner (non-physicians)	Physicians
<input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Physician Group
Outpatient Clinic / Facility	State Agencies
<input type="checkbox"/> Rural Health Clinic (RHC) <input type="checkbox"/> Federally Qualified Health Center (FQHC)	<input type="checkbox"/> Health Department

Certification and Accreditation

Please complete required certification and accreditation as applicable

Medicare Number	CLIA Number	DEA Number
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Certification

Certifying Entity

Current Effective date	Expiration Date	State	Certificate Number
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Accreditation

Accreditation Entity

Current Effective Date	Expiration Date	State	Accreditation Number
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Physical Address Information (Physical Site Location)

This is the physical location where service will be rendered, or in the case of mobile services, where management/supervision occurs. (No P.O. Boxes)

Address Line 1 *

Address Line 2

City *	State *	Zip Code+4 *
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County *

Contact Person (Authorized Individual)

Individual authorized to receive information or make business decisions on behalf of the applying provider.

Full Name (Last, First, Middle) *		Business Relationship to Enrolling Provider (Title) *	
Office Phone Number *	Ext	Other Phone Number	Ext
() -		() -	
Fax Number		Email Address *	
() -			

Servicing Counties

List the counties that eligible recipients may reside and choose your practice as their Primary Care Provider (PCP).

☐ Check if you serve all counties in North Carolina.

*			

Correspondence / Accounting Address Information

This is the address where all paper and accounting correspondence (other than Remittance Advices) is to be mailed.

☐ Check if correspondence address is the same as the physical address listed on this application

Attention *

Address Line 1 *

Address Line 2

City *

State *

Zip Code *

Correspondence Contact Person

☐ Check if correspondence person is the same as the contact person (authorized individual)

Full Name (Last, First, Middle) *

Business Relationship to Enrolling Provider (Title) *

Office Phone Number *

Ext

Other Phone Number

Ext

() -

() -

Fax Number

Email Address

() -

CCNC/CA Contact Person

☐ Check if CCNC/CA contact person is the same as the contact person (authorized individual).

☐ Check if CCNC/CA contact person is the same as the correspondence contact person.

Full Name (Last, First, Middle) *

Business Relationship to Enrolling Provider (Title) *

Office Phone Number *

Ext

Other Phone Number

Ext

() -

() -

Fax Number

Email Address

() -

Patients Accepted *

Are you accepting new patients?

Yes

No

If no, do you accept siblings of established patients?

Yes

No

Do you accept Medicaid for Pregnant Women (MPW) patients?

Yes

No

If yes, do you serve patients other than MPW?

Yes

No

Do you accept Chronic Infectious Disease patients?

Yes

No

Ages and Gender Served *

Please provide gender and ages served at the location.

☐ Male

Ages Served:

☐ Female

Ages Served:

Hours of Operation *

Indicate the hours the provider is available to see recipients at this location. Primary Care Providers (PCPs) must be available at each practice site a minimum of 30 hours per week. *

☐ Check if this location is open 24/7

	Open	Hours closed during the work day		Close
		Close	Open	
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				
Total hours available to see recipients				

After Hours Coverage or 24/7 Responder Coverage

The phone number will be the number that appears on a recipient's Medicaid Identification (MID) card. Referring automatically to the Emergency Department (ED) or Hospital Switchboard is not acceptable.

Phone Number *

() -

Type of after hours or 24/7 responder coverage *

- | | |
|--|---|
| <input type="checkbox"/> Answering Service | <input type="checkbox"/> Hospital operator who pages on-call provider |
| <input type="checkbox"/> Answering machine that gives phone number of the provider | <input type="checkbox"/> Call forward or stay-on-line transferring |
| <input type="checkbox"/> Nurse Triage Service | <input type="checkbox"/> 24 hour Hospital Switchboard |
| <input type="checkbox"/> Physician on call | <input type="checkbox"/> ER Triage |
| <input type="checkbox"/> Other: | |

Interpretation Services *

- | | | |
|---|------------------------------|-----------------------------|
| Are Oral Interpretation Services available? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is Braille supported? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is Sign Language Supported? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Languages Supported *

Select all languages that are spoken or supported at your physical location.

- | | | | |
|--|----------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> French | <input type="checkbox"/> Japanese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> German | <input type="checkbox"/> Korean | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Greek | <input type="checkbox"/> Persian | <input type="checkbox"/> Thai |
| <input type="checkbox"/> English | <input type="checkbox"/> Hindi | <input type="checkbox"/> Polish | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> French Creole | <input type="checkbox"/> Italian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Yiddish |
| <input type="checkbox"/> Other: | | | |

Special Needs

Check all special needs services your physical location is equipped to serve. *

- | | |
|--|--|
| <input type="checkbox"/> Blind / Visually Impaired | <input type="checkbox"/> Sexually Aggressive |
| <input type="checkbox"/> Deaf / Hearing Impaired | <input type="checkbox"/> Behaviorally Disruptive |
| <input type="checkbox"/> Physical Handicapped | |

TDD/TTY Phone Number

() -

Physician Extender Information

Are there physician extenders practicing at this location? * ☐ Yes ☐ No

If yes, please provide the following information for each physician extender practicing at this location.

Physician Extender 1

Full Name (Last, First, Middle)

- | | |
|---|---|
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Certified Advanced Practice Nurse Specialist |

Physician Extender 2

Full Name (Last, First, Middle)

- | | |
|---|---|
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Certified Advanced Practice Nurse Specialist |

Hospital Admitting

Does a clinician in this group or practice have hospital admitting privileges? * ☐ Yes ☐ No

If you answer no, you must complete a Carolina ACCESS Hospital Admitting Agreement form.

Please list all Hospitals that you have admitting privileges	County
1)	
2)	
3)	
4)	
5)	

Managing Relationships

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator), and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

Relationship 1

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 2

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 3

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 4

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 5

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 6

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Managing Relationships Continued . . .**Relationship 7**

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 8

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 9

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 10

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 11

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Relationship 12

Full Name (Last, First, Middle) *	
Social Security Number *	Date of Birth (MM/DD/CCYY) *
- -	/ /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Ownership Information

How would you describe the ownership? *

☐ Single-Owner LLC

☐ Sole Proprietor

☐ Federal

☐ State

☐ City/Municipality

☐ Indian Health Services

☐ Corporation

☐ Partnership

☐ Non-Profit

Corporation, Partnership, or Non-Profit:

Does anyone have direct or indirect ownership or control interest of 5% or more in the organization/entity? *

☐ Yes

☐ No

If you answered yes to the above question you must list ownership information for each owner who owns 5% or more.

Ownership 1

Full Name (Last, First, Middle) / Business Name *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Ownership 2

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Ownership 3

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Ownership 4

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Ownership 5

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc) *

Ownership Information Continued . . .**Ownership 6**

Full Name (Last, First, Middle) / Business Name*

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 7

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 8

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 9

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 10

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 11

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *

Date of Birth (MM/DD/CCYY) *

Ownership % *

Business Relationship to Enrolling Provider (Title)

Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

CCNC/CA Enrollees *

Requested Maximum number of CCNC/CA Enrollees

The maximum is 2000 enrollees per participating provider, including Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives.

Preventive and Ancillary Services *

Samples and specimens must be collected on-site, but may be sent out for testing. At least one location must be specified for each service.

Service Name	On-Site	Off-site
Adult Preventive Annual Health Assessment Services	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Screening	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer Screening	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria, Tetanus, Pertussis Vaccine (DtaP)	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilus Influenzae Type b Vaccine (Hib)	<input type="checkbox"/>	<input type="checkbox"/>
Health Check Screening Exam	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Assessment (using electronic equipment, e.g. audiometer)	<input type="checkbox"/>	<input type="checkbox"/>
Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Inactivated Polio Vaccine (IPV)	<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Measles, Mumps, Rubella Vaccine (MMR)	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Vaccine (PCV)	<input type="checkbox"/>	<input type="checkbox"/>
Standardized Written Developmental Screening (e.g. Ages and Stages, PEDS)	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus Vaccine (Td)	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculin (TB) Testing (via PPD intradermal injection/Mantoux method)	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>
Varicella Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Vision Assessment (e.g., Snellen Chart)	<input type="checkbox"/>	<input type="checkbox"/>

Border Providers Only - Home State Medicaid Program Information

Please provide identifying information regarding your home state's Medicaid program.

NPI Number *

Provider Number

State Medicaid Program Address 1 *

State Medicaid Program Address 2

City *

State *

Zip *

State's Medicaid Phone Number *

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Exclusion Sanction Information *

For the following questions, the word "you" and "your" shall mean the enrolling provider, its owners, and its agents in accordance with 42 CFR 455.100; 101; 102; 104; 105; 106 and 42 CFR 1001.1001 et seq.:

* An agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. This includes, but is not limited to, managing employees, Board Members and Electronic Funds Transfer (EFT) authorized individuals.

* A managing employee is defined as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the enrolling provider.

* An entity shall include, but not be limited to, a corporation, limited liability company, partnership, business, provider organization, or professional association.

For each question answered yes, the applicant must attach or submit a complete copy of the applicable criminal complaint, Consent Order, documentation, licensure action, suspension, penalty or recoupment notice, and/or final disposition clearly indicating the final resolution. Submitting a written explanation in lieu of supporting documentation may result in the denial of this application.

Note: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

A.	Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, pled no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense?	Yes	No
B.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had disciplinary action taken against any business or professional license held in this or any other state, including licenses issued by the North Carolina Division of Health Service Regulation (NC DHSR) and endorsements issued by any Local Management Entity as that term is defined in N.C.G.S. 122C-115.4?	Yes	No
C.	Has your license to practice ever been restricted, reduced or revoked in this or any other state or been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying or professional standards board or agency?	Yes	No
D.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?	Yes	No
E.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had payments suspended by Medicare or Medicaid in any state?	Yes	No
F.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including NC DHSR, even if the fine(s) have been paid in full?	Yes	No
G.	Have Medicare or Medicaid in any state ever taken recoupment actions against you or any entity you are or were either an agent, owner, or managing employee of?	Yes	No
H.	Do you or any entity you are or were either an agent, owner, or managing employee of, owe money to Medicare or Medicaid that has not been paid in full?	Yes	No
I.	Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?	Yes	No
J.	Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	Yes	No
K.	Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct?	Yes	No
L.	Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?	Yes	No

Affiliated Provider Information

Provide the individual NC DHHS Number, NPI, and the name information for each provider that you wish to link or affiliate with this organization. Physician and Nurse Practitioner groups must have at least one individual provider who is actively enrolled as a NC Medicaid Provider.

[illegible]

Consent to Release Information

I understand that the North Carolina Division of Medical Assistance (DMA) and its representatives is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA and its representatives to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program's credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

Signature of Authorization Required

Information Must Be Entered For The Agreement To Be Processed

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

Signature of Authorized Individual *

Date *

Print Name *

Title *



North Carolina Department of Health and Human Services

PROVIDER ADMINISTRATIVE PARTICIPATION AGREEMENT

1. Parties to the Agreement

This Medicaid Provider Administrative Participation Agreement ("Agreement") is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the "Department", and the below identified provider, hereinafter referred to as the "Provider."

STATE/FISCAL AGENT USE ONLY

- ☐ Initial Enrollment
- ☐ Re-Enrollment
- ☐ CHOW
- ☐ Other Change

2. Agreement Document

The Agreement Documents shall consist of this Agreement, any addendum, and the Provider's application, incorporated herein by reference. Except for changes to DHHS medical coverage policies, or other guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent as referenced in Section 3, below, no alterations or modifications shall be made to the terms of the Agreement unless through a written amendment executed by both parties.

3. Governing Law and Venue

This Agreement is required by 42 CFR §431.107 and shall be governed by the following (hereinafter referred to as the "Controlling Authority"):

- (a) Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, and any Title XIX waivers authorized by the Centers for Medicare and Medicaid Services (CMS); and
- (b) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, including but not limited to the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards; and
- (c) The Family Educational Rights and Privacy Act (FERPA); and
- (d) N.C.G.S §108A-80; and
- (e) The following that are consistent with and expressly or implicitly authorized by the authority in subdivision (a) herein: state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered.

By execution of this Agreement, the Provider does not release, waive or modify in any way any procedural or substantive rights it may have pursuant to Controlling Authority related to its participation in the Medicaid program. In case of conflict between any provision of this Agreement and any current or future provision of Controlling Authority, the Controlling Authority shall govern and the terms of this Agreement shall be deemed to be modified so as to comply with Controlling Authority. In the event of a

lawsuit or administrative petition involving this Agreement, venue is proper in Wake County, North Carolina.

The Provider agrees to operate and provide services in accordance with the Controlling Authority. Unless otherwise required by this Agreement or Controlling Authority, the Department may publish notice of changes in policies, guidelines, or other procedures on its website within 30 days advance notice to provide for implementation thereof.

Nothing in this Agreement creates in the provider a property right or liberty right in continued participation in the North Carolina Medicaid program.

4. License

The Provider agrees to:

- a. Be licensed, certified, registered, accredited and/or endorsed as required by Controlling Authority or Department policy, as appropriate for the service provided by the Provider, at all times those services are provided.
- b. Notify the Department within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.

5. Billing and Payment

The Provider agrees:

- a. To submit claims for services rendered to eligible North Carolina Medicaid recipients (hereinafter "recipients") in accordance with rules and billing instructions in effect at the time the service is rendered. Provider agrees to be responsible for research and correction of all billing discrepancies in claims submitted by the Provider or its authorized agent.
- b. To accept as sole and complete remuneration the amount paid in accordance with the finally determined reimbursement rate for services covered by the Department, except for payments from legally liable third parties, and authorized co-payments, coinsurance and/or deductibles authorized by the Controlling Authority or the Department. A Provider may bill for goods, services, or supplies provided to a recipient if such are not covered under Medicaid and the recipient has been notified in advance that such services are not covered and that the recipient is financially responsible. By agreeing to this provision, the Provider does not waive any potential rights to challenge or appeal its reimbursement rate or payment calculation in accordance with Controlling Authority.
- c. That in no event shall the Department be liable or responsible, either directly or indirectly, to any subcontractor of the Provider or any other party that may provide services.
- d. To be held to all the terms of this Agreement even though a third party agent may be involved in billing claims to the Department. It is a breach of the Agreement to assign the right to payment under this Agreement to a third party in violation of 42 CFR §447.10.
- e. To inquire about other coverage and bill other insurers and third parties, including the Medicare program, if applicable, before billing the Department, when the recipient is eligible for payment for health care or related services from another insurer or person.
- f. To not bill the recipient or any other person for items and services covered by Medicaid and to refund payments made by the recipient or by a third party on behalf of the recipient for Medicaid covered services for any claims for which the recipient has been approved for payment by the Department, including retroactive authorization for payment. No refund is due by the Provider to the recipient or any

- other person until payment to the Provider is final and has been made in full by Medicaid to the Provider.
- g. To accept assignment of Medicare payment in order to receive payment from the Department for amounts not covered by Medicare for dually eligible recipients.
 - h. To refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the Provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the Provider or the Department and/or its agents.
 - i. That payment for covered services by the Department is limited to those services that are medically necessary. Medical necessity and appeals of medical necessity determinations will be determined in accordance with the Controlling Authority.
 - j. That items or services provided under arrangements or contracts between the Provider and outside entities and professionals shall meet the same professional standards and principles as herein agreed to by the Provider.
 - k. That payment and satisfaction of claims will be from federal and state funds.
 - l. That claims are subject to the Medical Assistance Provider False Claims Act (Part 7, Article 2, Chapter 108A of the General Statutes), the North Carolina False Claims Act, Chapter 1, Article 51 of the North Carolina General Statutes (N.C.G.S §§1-605 through 617), and the federal False Claims Act.
 - m. That the Department may withhold payments because of irregularity without regard to cause until such irregularity is resolved, or may recoup or recover overpayments, penalties or invalid payments due to error of the Provider and/or the Department and their agents. The Department shall provide timely notice to the Provider that states the Department's reasons for withholding payments, the conditions that must be met to resolve the irregularity and the Provider's right to appeal. This withhold shall be subject to adjustment in accordance with Controlling Authority as a result of any contrary final determination in any challenge or appeal brought by the Provider. The Department may also withhold or suspend payments to a Provider as authorized by Controlling Authority. A Provider that is subject to a withhold recoupment, recovery, suspension, or penalty initiated by the Department shall not directly or indirectly bill through a different provider number for the purpose of evading the action.
 - n. Any Providers that share the same IRS Employee Identification Number are equally subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until any overpayment, penalty, or invalid payment incurred by such Provider(s) is resolved, either by payment in full or final agency decision. Any Provider that does not share the same Employee Identification Number but that is more than fifty percent (50%) owned, in whole or in part, by an individual or entity that has more than fifty percent (50%) ownership interest in a separate provider entity that owes an outstanding overpayment, penalty, or invalid payment to the Department shall also be subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until such overpayment, penalty, or invalid payment is resolved, either by payment in full or final agency decision.
 - o. That billings and reports related to services rendered shall be submitted in the format and frequency specified by the Department, any of its divisions and/or its fiscal agent. Failure to file mandatory reports or required disclosures within the time frames established by Department rule or policy may result in suspension of payments and/or other enforcement actions.
 - p. That claims shall be received by the Department within 365 calendar days of the date of service except as otherwise provided by Controlling Authority.
 - q. That electronic and non-electronic Medicaid claims may be submitted without signature and same is binding upon Provider, its employees, or its agents who provide services to recipients or who file claims under the Provider name and identification number.
 - r. That all claims shall be true, accurate, and complete and that services billed shall be personally furnished by Provider, its employees, or persons with whom the Provider has contracted to render services, under its direction.
 - s. That, except for hospital services as set forth in 42 CFR §413.65 the assigned Medicaid Provider Number

is specific to the Provider name and site location identified on the signature page of this Agreement, and that Provider shall not bill for services provided at or from other site locations using Medicaid Provider Number assigned to the site location identified on the signature page of this Agreement.

- t. That any change of ownership of Provider shall not be approved unless and until the new owner/entity agrees in writing to assume all liability, including but not limited to cost report settlements, health care assessment settlements, or recoupment actions, that have arisen or that may arise in connection with claims billed by Provider.
- u. To not bill the Department for services that were rendered during any period in which the institutional or professional license, certification, registration, accreditation and/or endorsement required of the individual or entity providing the service has become invalid due to suspension or termination by the issuing agency.

6. Disclosure

- a. At any time during the course of this Agreement, the Provider agrees to notify the Department at the North Carolina Department of Health and Human Services, Division of Medical Assistance, Provider Services Section, of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in:
 - i. ownership;
 - ii. licensure;
 - iii. federal tax identification number;
 - iv. bankruptcy;
 - v. additions, deletions, or replacements in group membership; and
 - vi. any change in address or telephone number.
- b. The Provider agrees to submit to the Department upon request professional, business, and personal information concerning the Provider, any person with an ownership interest in the Provider, and any authorized agent of the Provider in accordance with the disclosure requirements set forth in 42 CFR Chapter IV, part 455, Subpart B. Such submittal shall include:
 - i. Proof of a valid license, operating certificate, and/or certification if required by Controlling Authority or policy, or rule of a local jurisdiction in which the Provider is located and that is consistent with Controlling Authority.
 - ii. Any prior or current violation, recoupment, fine, suspension, termination, or other administrative action taken relative to medical or behavioral health care benefit programs under (a) federal or State law, policy, or rule; or (b) Department policy(ies) or (c) the laws or rules of any other state, Medicare, or any regulatory body.
 - iii. Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other medical or behavioral health care provider or medical or behavioral health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide medical or behavioral health care services.
- c. The Provider agrees to furnish on request, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.
- d. The Provider agrees to submit to a criminal background check before or anytime after approval of this agreement.

- e. The Provider agrees to screen all its employees and contractors regularly using the List of Excluded Individuals/Entities (LEIE) database to determine whether any of its employees or contractors is excluded from participation in Medicare, Medicaid, or other federal health care programs. The LEIE database is maintained by the United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG) and can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The Provider shall promptly notify the Department upon discovery that any employee or contractor is on the LEIE. Provider understands and acknowledges that employment of or contractual arrangements with persons listed in the LEIE will subject the Provider, in accordance with Controlling Authority, to recoupment of funds paid to the Provider during the period in which the employment or contract was in effect.
- f. The Provider agrees to comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR Chapter IV, part 489, subpart I and 42 CFR §417.436(d).

7. Inspection; Maintenance of Records; Filing Reports

- a. For a minimum of six years from the date of services, or longer if required specifically by Controlling Authority, the Provider shall:
 - i. Promptly furnish upon request copies of any and all documentation set forth below in subpart ii of this paragraph, whether in the possession of contractors, agents, or subcontractors, for review by the Department, its agents and/or assigns. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for medical or behavioral health care services not adequately documented, and may result in the termination or suspension of the Provider from participation in the Medicaid program. The Provider further understands that it is the Department's position that failure to promptly furnish records upon request creates a presumption that the records do not exist.
 - ii. Keep, maintain and make available complete and accurate medical and fiscal records in accordance with Department record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Department. For providers who are required to submit annual cost reports, fiscal records shall include invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, and such other records as may be required by Controlling Authority or Department policy.
- b. Post payment audits or investigation may be conducted to determine compliance with the rules and regulations of the Department. If the Provider is notified that an audit or investigation has been initiated, the Provider shall retain all original records and supportive materials until the audit or investigation is completed and all issues are resolved if the period of retention extends beyond the minimum required 6-year period.
- c. Federal and State officials, employees and their agents may visit Provider facilities to make certification and compliance surveys, inspections, medical and professional reviews, and audits of costs and data relating to services to recipients. Such visits including unannounced visits must be allowed at any time during normal hours of operation. Failure to grant immediate access upon reasonable request may result in suspension of the Provider and/or of reimbursements.

8. Termination

Subject to applicable provisions of Controlling Authority:

- a. Either the Department or the Provider may terminate this Agreement with or without cause at any time upon 30 days written notification to the other;

- b. The Department may summarily terminate without giving 30 days written notice under the following circumstances:
- i. The Provider does not meet conditions for participation, including necessary licensure, certification, or endorsement requirements or other terms and conditions stated in this Agreement; or
 - ii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense set forth in 42 CFR §1001.101 or 42 CFR §1001.201; or
 - iii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct, or crime of moral turpitude; or
 - iv. The Provider fails to disclose information required under 42 CFR §1002.3; or
 - v. Any person with ownership or controlling interest in the Provider, or an agent as that term is defined in accordance with 42 CFR §1001.1001 or managing employee of the Provider, has been excluded by the United States Department of Health and Human Services from participation in the Medicare or Medicaid programs; or
 - vi. The Provider poses an imminent health or safety risk to a patient; or
 - vii. The Provider has been found by the Department to be in breach or violation of any law, rule, or policy for which summary termination is authorized by Controlling Authority or by a rule authorized by and consistent with the Controlling Authority and adopted pursuant to Chapter 150B of the General Statutes; or

The Provider's right to appeal or otherwise contest any termination shall be determined in accordance with Controlling Authority.

9. Assignment

The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement to a third party except as allowed by federal law.

10. Release of Liability

The Provider agrees to fully release and discharge the State of North Carolina, the Department and any of their officers, agents and employees, from any and all liability, claims and causes of action that may be brought by third parties against the Provider arising out of this Agreement. This is a complete and irrevocable release and waiver of liability. The State of North Carolina, the Department, and any of their officers, agents and employees are not liable for claims and causes of action that may be brought by third parties arising out of any act or omission of the Provider or any subcontractor.

11. Severability

The provisions of this Agreement are severable. If any provision of the Agreement is held invalid by any court that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be modified to conform to existing law.

12. Independent Contractor

The Provider or its directors, officers, partners, employees and agents are not employees or agents of the Department.

13. Discrimination

The Provider agrees that the Department may make payments for medical or behavioral health care services rendered to Department recipients only to a person or entity who has a provider agreement in effect with the Department; who is performing services or supplying goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964; Section 504 of the 1973 Rehabilitation Act; the 1975 Age Discrimination Act; the 1990 Americans With Disabilities Act; and all applicable federal and state statutes and regulations relating to the protection of human subjects of research. The authority of the Department and its Division of Medical Assistance to limit payment to the Provider under this Section or otherwise shall be restricted exclusively to payments for services rendered on specific dates as to which the above-referenced requirements were not met.

14. Waiver

No waiver of any term, right or condition of this Agreement shall be valid unless it is set forth in a writing duly executed by both parties. No delay or failure by either party to exercise or enforce at any time any right or provision of this Agreement will be considered a waiver thereof or of such party's right thereafter to exercise or enforce each and every right and provision of the Agreement. No single waiver will constitute a continuing or subsequent waiver.

15. Survival

All provisions of this Agreement which by their nature give rise to continuing obligations of the parties shall survive the expiration or termination of this Agreement, including without limitation the terms of paragraphs 3, 5, 7, 9, and 10.

16. Effective Date

This Agreement is effective on the date the Provider meets all requirements of participation as set forth in 42 CFR §431.108.

Required Fields are marked with an asterisk (*).

*Medicaid Provider Name (Last, First, Middle or Organization Name)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

*Street Address Line 2

*Phone Number

*City

*State

*Zip Code + Four (Last 4 digits required)

*Correspondence Address Line 1 (Accounting)

*Correspondence Address Line 2

*City

*State

*Zip Code + Four (Last 4 digits required)

* Medicaid Provider Number (if applicable)

I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

*Signature of Applicant or Authorized Agent

*Date

*Printed Name and Title

DHHS/DMA/FISCAL AGENT APPROVAL

*Signature

*Date



North Carolina Department of Health and Human Services MEDICAID LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall –

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 *et seq.*], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner/ operator/ manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least \$5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 *et seq.*, administrative remedies for false claims and statements established under 31 USCS §. 3801 *et seq.*, and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City

*State

*Zip Code + Four (Last 4 digits required)

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Signature of Applicant or Authorized Individual

*Date

*Printed Name and Title

Required Fields are marked with an asterisk (*).



North Carolina Department of Health and Human Services
Division of Medical Assistance
PROVIDER CERTIFICATION FOR SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

A separate certification is required for each individual in the group in addition to the group certification.

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

*Signature of Applicant or Authorized Individual *Date

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date: _____ by _____



North Carolina Department of Health and Human Services

Division of Medical Assistance

Instructions for Completing the Electronic Claims Submission (ECS) Agreement

Providers who plan to submit claims electronically must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims.

The ECS Agreement is not transferable from one group practice to another, from one owner of a group practice to another or for individual providers affiliated with a group practice moving to another group practice or a solo practice.

Who Needs to Submit an ECS Agreement?

1. Currently enrolled organizations (group practices or agencies/facilities) who did not elect to submit claims electronically at the time of their initial enrollment must complete and submit an ECS Agreement prior to beginning electronic claims submission. The ECS Agreement must include the original signature of each individual provider affiliated with your group.
2. Currently enrolled organizations (group practices) who completed and submitted an ECS Agreement and who have subsequently added new individual providers to their group practice must complete and submit an additional ECS Agreement with the original signature of the new individual providers.
3. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

How to Complete the Form:

1. Type or print in black ink.
2. The ECS Agreement cannot be altered; text cannot be highlighted, struck through, or obstructed through the use of correction fluids.
3. The ECS Agreement must be submitted to CSC by mail; ECS Agreements sent by fax are not acceptable.
4. Provider Name
 - a. Enter the name of your group practice or agency/facility.
 - b. The provider name entered on the ECS Agreement must match the name on file with the N.C. Medicaid Program (as indicated on your Remittance and Status Report).
 - c. If the name of your group practice or agency/facility has changed, you must submit a correction according to the process outlined on CSC's website at <http://www.nctracks.nc.gov/provider/cis.html>.
 - d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.

5. Provider Number

Enter the Medicaid Provider Number for the group practice or agency/facility. Payments will be made to this Medicaid Provider Number.

6. Business Site/Physical Address

- a. Enter the physical address for the group practice or agency/facility. (The physical address is the street address for the location where services will be rendered.)
- b. The physical address entered on the ECS Agreement must match the address on file with the N.C. Medicaid Program.
- c. If the physical address for your group practice has changed, you must submit a correction according to the process outlined on CSC's website at <http://www.nctracks.nc.gov/provider/cis.jsp>.
- d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.

7. Group Practice Member Information

- a. This portion of the ECS Agreement must be completed by an enrolled group practice when they elect to submit claims electronically. Enter the name and Medicaid Provider Number for each individual provider affiliated with your group for whom you will be submitting claims using your group provider number. This is required even if there is only one provider in the group.
- b. This portion of the ECS Agreement must be completed by an enrolled group practice when a new individual is added to the group practice. Enter the name and Medicaid Provider Number for only the new individual provider for whom you will be submitting claims using your group provider number.
- c. The individual provider(s) must sign where indicated. All signatures must be original; signature stamps and copies are not acceptable.
- d. This portion of the ECS Agreement is not applicable to agency/facility providers.

8. Signature Authorization and Related Information

An authorized agent such as the medical director, owner, vice president, business officer, etc., who has the authority to enter into contracts on behalf of the group must sign group ECS Agreement.

- a. All signatures must be original.
- b. Signature stamps are not acceptable.
- c. Photocopies are not acceptable.

9. Claims should not be submitted electronically until notification of approval of the ECS Agreement is received from CSC. You must contact the ECS unit at EDS by calling 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) to obtain an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to CSC:

USPS Mail:

CSC EVC Center
P. O. Box 300020
Raleigh, NC 27622-8020

For certified /overnight mail only:

CSC EVC Center
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073



North Carolina Department of Health and Human Services Division of Medical Assistance ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

1. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.
2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.
3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.
4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.
5. The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.
6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents.

Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.
8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.
9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.
10. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.
11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.
12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.
13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.
14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name: _____
(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

*Provider Name	*Provider Individual Number	*Signature of Provider

NC Medicaid Provider Enrollment | CSC EVC Center
P.O. Box 300020 | Raleigh, NC 27622-8020

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Signature of Authorized Agent

*Date

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL	
Acceptance Date	by

Substitute W-9

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt
payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* in the instructions.

Social security number

or

Note. If the account is in more than one name, see the Instructions for guidelines on whose number to enter.

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions.

Sign
Here

Signature of
U.S. person ▶

Date ▶



**North Carolina Department of Health and Human Services
Division of Medical Assistance
AGREEMENT FOR PARTICIPATION AS A PRIMARY CARE PROVIDER IN
NORTH CAROLINA'S PATIENT ACCESS AND COORDINATED CARE
PROGRAM (CAROLINA ACCESS)**

This agreement is between the State of North Carolina, Department of Health and Human Services Division of Medical Assistance, whose principal office is located in the City of Raleigh, County of Wake, State of North Carolina, hereinafter referred to as the "Division"

and * _____ (Name of Primary Care Provider) located in the city of * _____,

county of * _____, State of North Carolina or State of _____

hereinafter referred to as the "Contractor."

WHEREAS, the Division, as the single State agency designated to establish and administer a program to provide medical assistance to the indigent under Title XIX of the Social Security Act, is authorized to contract with health care providers for the provision of such assistance on a coordinated care basis;

NOW, THEREFORE, it is agreed between the DIVISION and the CONTRACTOR, as follows:

I. General Statement of Purpose and Intent

The Division desires to contract with providers willing to participate in the North Carolina Medical Assistance Program (Medicaid) to provide primary care directly and to coordinate other health care needs through the appropriate referral and authorization of Medicaid services. This program, Carolina ACCESS, applies to certain Medicaid recipients who may select or be assigned to the Contractor. This agreement describes the terms and conditions under which this agreement is made and the responsibilities of the parties thereto.

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Division and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Division and Contractor that any such person or entity, other than the Division or the Contractor, receiving services or benefits under this Contract shall be deemed an incidental beneficiary only.

II. General Statement of the Law

North Carolina's Patient Access and Coordinated Care Program (Carolina ACCESS) is a primary care patient coordination system implemented pursuant to Title XIX of the Social Security Act, and is subject to the provisions of North Carolina Statutes and North Carolina Administrative Code. This agreement shall be construed as supplementary to the usual terms and conditions of providers participating in the Medicaid program, except to the extent superseded by the specific terms of this agreement. The Contractor agrees to abide by all existing laws, regulations, rules, policies, and procedures pursuant to the Carolina ACCESS and Medicaid program.

The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, are governed by the laws of North Carolina. The Contractor, by signing this Contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the only venue for any legal proceedings shall be Wake County, North Carolina. The place of this Contract, and all transactions,

agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation, and enforcement, shall be determined.

III. Definitions-The following terms have the meaning stated for the purposes of this agreement:

Application- All forms and supplements to this agreement that the provider uses to apply for participation with the Carolina ACCESS program. This agreement shall be effective subject to approval of the Application by the Division.

Carolina ACCESS Policy- All policies and procedures required by this agreement and incorporated herein by reference are published in the *General Medicaid Billing Guide* which is published on the Division's website at <http://www.dhhs.state.nc.us/dma/>.

C.F.R.- Code of Federal Regulations.

Contractor- The Primary Care Provider (PCP) entering into this agreement with the Division of Medical Assistance.

Division- The Division of Medical Assistance of the North Carolina Department of Health and Human Services.

Eligible Recipient- Medicaid recipients who are enrolled in the Carolina ACCESS program.

Enrollee- A Medicaid recipient who chooses or is assigned to a Carolina ACCESS primary care provider.

Group Practice/Center- A Medicaid participating primary care provider structured as a group practice/center which (1) is a legal entity (e.g., corporation, partnership, etc.), (2) possesses a federal tax identification (employer) number, and (3) is designated as a group by means of a Medicaid Group Provider number.

Management/Coordination Fee- The amount paid to the Contractor per member per month for each Carolina ACCESS recipient who has chosen or has been assigned to the Contractor.

Medicaid- The North Carolina Medical Assistance Program.

Medically Necessary- The term "Medical Necessity" is defined by Division policy.

Patient Care Coordination- The manner or practice of providing, directing, and coordinating the health care and utilization of health care services of enrollees with regard to those services as defined by Carolina ACCESS Policy that must be authorized by the primary care provider. If not provided directly, necessary medical services must be arranged through the primary care provider.

Potential Enrollee- A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific Primary Care Provider.

Preventive Services- Services rendered for the prevention of disease in adults and children as defined by Carolina ACCESS Policy.

Primary Care- The ongoing responsibility for directly providing medical care (including diagnosis and/or treatment) to an enrollee regardless of the presence or absence of disease. It includes health promotion, identification of individuals at risk, early detection of serious disease, management of acute emergencies, rendering continuous care to chronically ill patients, and referring the enrollee to another provider when necessary.

Primary Care Provider- The participating physician, physician extender (PA, FNP, CNM), or group practice/center selected by or assigned to the enrollee to provide and coordinate all of the enrollee's health care needs and to initiate and monitor referrals for specialized services when required.

Recipient Disenrollment- The deletion of the individual from the monthly list of enrollees furnished by the Division to the Contractor.

Women, Infants, and Children (WIC) Program- The Special Supplemental Food Program created by Congress in 1972 to meet the special nutritional needs of pregnant, breastfeeding and postpartum women, and of infants and children up to age five (5).

IV. Functions and Duties of the Contractor

In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

The Contractor is and shall be deemed to be an independent Contractor in the performance of this Contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this Agreement. Such employees shall not be employees of, or have any individual contractual relationship with, the Division.

The Contractor shall not subcontract any of the work contemplated under this Contract without prior written approval from the Division. Any approved subcontract shall be subject to all conditions of this contract. Only the subcontractors specified in the Contractor's application are to be considered approved upon award of the contract. The Contractor shall be responsible for the performance of any subcontractor. The Division shall not be responsible to pay for work performed by unapproved subcontractors.

The Carolina ACCESS Contractor agrees to do the following:

- 4.1 Accept enrollees pursuant to the terms of this agreement and be listed as a primary care provider in the Carolina ACCESS program for the purpose of providing care to enrollees and managing their health care needs.
- 4.2 Provide Primary Care and Patient Care Coordination services to each enrollee in accordance with the provisions of this agreement and the policies set forth in Medicaid provider manuals and Medicaid bulletins and as defined by Carolina ACCESS Policy.
- 4.3 Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Carolina ACCESS Policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- 4.4 Provide direct patient care a minimum of 30 office hours per week or as defined by Carolina ACCESS Policy.
- 4.5 Provide preventive services as defined by Carolina ACCESS Policy.
- 4.6 Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Carolina ACCESS Policy.
- 4.7 Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Carolina ACCESS Policy.
- 4.8 Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record. Provide the authorization number (Carolina ACCESS provider number) to the referral provider either in writing or by telephone as defined by Carolina ACCESS Policy.
- 4.9 Transfer the Carolina ACCESS enrollee's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request.
- 4.10 Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Carolina ACCESS Policy.
- 4.11 Refer for a second opinion as defined by Carolina ACCESS policy.
- 4.12 Review and use all enrollee utilization and cost reports provided by the Carolina ACCESS Program for the purpose of practice level utilization management and advise the Division of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Carolina ACCESS Policy. A signed Provider Confidential Information and Security Agreement is required for online access to these reports. The form is published on the Division's web page at <http://www.dhhs.state.nc.us/dma>.

- 4.13 Participate with Division utilization management, quality assessment, and administrative programs.
- 4.14 Provide the Division or its duly authorized representative or the Federal government unlimited access (including on site inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.
- 4.15 Refer potentially eligible enrollees to the WIC Program with the enrollee's consent to the release of relevant medical record information.
- 4.16 Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the North Carolina Physicians Advisory Group.
- 4.17 Notify the Division or its agents of any and all changes to information provided on the initial application for participation.
- 4.18 Give written notice of termination of this contract, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis.
- 4.19 Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.
- 4.20 Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.
- 4.21 Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act.
- 4.22 Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.
- 4.23 Receive prior approval from the Division of any marketing materials prior to distribution. Marketing materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits. Marketing materials shall not make any assertion or statement that the Contractor is endorsed by CMS, the Federal or State government or similar entity.
- 4.24 Refrain from door-to-door, telephonic or other 'cold-call' marketing; engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the Contractor, its marketing representatives, or the Division.
- 4.25 Refrain from knowingly engaging in a relationship with the following:
 - an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
 - an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the Contractor,
- A person with beneficial ownership of more than five percent (5%) or more of the Contractor's equity; or,
- A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's contractual obligation with the Division.

- 4.26 Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends.)

V. Functions and Duties of the Division

The Division agrees to do the following:

- 5.1 List the Contractor's name as a primary care provider in the Carolina ACCESS program.
- 5.2 Pay the Contractor on a fee-for-service basis in accordance with the Medicaid fee schedule and billing guidelines. Any monthly management/coordination fee paid in addition to the fee-for-service Medicaid payments will be paid per member per month, subject to the maximum number of enrollees under paragraph 6.1.A. The amount of the management/coordination fee, if any, may be adjusted according to practice performance parameters as defined by the Division. Multiple providers within a group practice are considered a single entity for purposes of the management/coordination fee.
- 5.3 Provide the Contractor with a monthly list of enrollees who have selected or have been assigned to him/her for the purpose of managing their health care needs.
- 5.4 Provide training and technical assistance regarding the Carolina ACCESS program.
- 5.5 Provide the Contractor with periodic utilization and cost reports.
- 5.6 Gather and analyze data relating to service utilization by enrollees to determine whether Contractors are within acceptable Carolina ACCESS peer comparison parameters.
- 5.7 Publish the *General Medicaid Billing Guide* and the Medicaid General and Special Bulletins on the Division's website at <http://www.dhhs.state.nc.us/dma>. All such policies, procedures, Medicaid provider bulletins and manuals are incorporated into this agreement by reference.
- 5.8 Provide an ongoing quality assurance program to evaluate the quality of health care services rendered to enrollees.
- 5.9 Provide program education to all enrollees through the local Department of Social Services or duly authorized representatives during eligibility reviews or within a reasonable timeframe. The recipient will receive accurate oral and written information needed to make an informed decision on whether to enroll.
- 5.10 Provide potential enrollees and enrollees with the *Carolina ACCESS Medicaid Managed Care Recipient Handbook* that contains program information including enrollee rights and protections, program advantages, enrollee responsibilities, complaint and grievance instructions. The *Carolina ACCESS Medicaid Managed Care Recipient Handbook* is also published on the Division's website at <http://www.ncdhhs.gov/dma/ca/>.
- 5.11 Notify enrollees that oral interpretation is available for any language and written material is available in prevalent languages and how to access these services.
- 5.12 Provide written materials that use easily understood language and format. Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- 5.13 Inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
- 5.14 Provide marketing materials to potential enrollees.

VI. General Terms and Conditions

6.1 Recipient Enrollment and Disenrollment

A. Recipient Enrollment

The Contractor must accept individuals in the order in which they apply without restriction up to the limits set by the contract. The Contractor may specify a limit on the number of enrollees on the Carolina ACCESS Application for Participation subject to the following terms and conditions:

- Maximum enrollment is set at 2,000 enrollees per physician or physician extender unless otherwise approved by the Division.
- Notwithstanding the enrollment limits specified above, the Contractor may receive an enrollment that slightly exceeds these limits due to the nature and timing of the enrollment process.
- The Contractor may set enrollment criteria on the Application, but must accept recipients who meet the enrollment criteria up to the limit specified.
- The Contractor may change the enrollee limit by notifying the Division.
- The Contractor must restrict enrollment to recipients who reside sufficiently near the delivery site to reach that site within a reasonable time using available and affordable modes of transportation.

B. Recipient Choice

1. Eligible Recipients may choose from among participating Contractors who are available to their county of residence when those Contractors' enrollment limits have not been exceeded.
2. Eligible Recipients who do not choose a primary care provider shall be assigned to an appropriate participating provider available to their county of residence based on historic usage, location and/or randomly by rotating assignment.
3. All recipient enrollments, disenrollments and changes are effective on the first day of the month, pursuant to processing deadlines and will be indicated on the Enrollment Report.

C. Recipient Disenrollment

1. Enrollees shall be permitted to change primary care providers according to Carolina ACCESS Policy. Transfer of medical records is addressed in Section 4.9 of this agreement.
2. The Contractor may request the disenrollment of an enrollee for good cause as defined by Carolina ACCESS Policy.
3. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees).
4. The Carolina ACCESS Medicaid Managed Care Recipient Handbook includes complaint and grievance instructions and is provided to potential enrollees and enrollees. This handbook is also published on the Division's website at <http://www.dhhs.state.nc.us/dma/>.
5. If the Division fails to make a disenrollment determination so that the recipient can be disenrolled no later than the first day of the second month following the month in which the recipient or the Contractor files the request, the disenrollment is considered approved.

6.2 Contract Violation Provisions

The failure of a Contractor to comply with the terms of this agreement may result in the following sanctions by the Division:

- A. Limiting member enrollment with the Contractor.
- B. Withholding all or part of the Contractor's monthly Carolina ACCESS management/coordination fee.
- C. Referral to DMA Program Integrity Unit for investigation of potential fraud or quality of care issues.
- D. Referral to North Carolina Medical Board.
- E. Termination of the Contractor from the Carolina ACCESS program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Division based on the severity of the agreement violation. The Division makes the determination to initiate sanctions against the Contractor. The Contractor will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Division determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the Contractor disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Carolina ACCESS Policy.

Failure of the Division to impose sanctions for an agreement violation does not prohibit the Division from exercising its rights to do so for subsequent agreement violations.

Federal Financial Participation (FFP) is not available for amounts expended for Contractors excluded by Medicare, Medicaid or State Children's Health Insurance Program (SCHIP), except for emergency services.

6.3 Application Process

The Contractor will complete an Application to submit with the signed agreement for review and approval by the Division.

6.4 Exceptions to the Agreement

The Division may approve exceptions to this agreement if, in the opinion of the Division, the benefits of the Contractor's participation outweigh the Contractor's inability to comply with a portion of this agreement.

In order to amend this agreement, the Contractor shall submit a written request to the Division for consideration for exception from a specific agreement requirement. The request shall include the reasons for the Contractor's inability to comply with this agreement requirement. The request shall be submitted at the time this agreement is submitted to the Division for consideration. Approval of the Application constitutes acceptance of the request for an exception.

6.5 Transfer of Agreement

This agreement may not be transferred.

6.6 Contract Termination

This agreement may be terminated by either party, with cause, or by mutual consent, upon at least thirty (30) days written notice delivered by certified mail with return receipt requested and will be effective only on the first day of the month, pursuant to processing deadlines.

The Division under the following conditions may terminate this agreement immediately:

1. In the event that state or federal funds that have been allocated to the Division are eliminated or reduced to such an extent that, in the sole determination of the Division, continuation of the obligations at the levels stated herein may not be maintained. The obligations of each party shall be terminated to the extent specified in the notice of termination immediately upon receipt of notice of termination from the Division; or

- The Contractor must supply all information necessary for reimbursement of outstanding Medicaid claims.

This agreement shall become effective on [REDACTED] (to be completed by DMA office staff) and remain in effect until amended or terminated pursuant to the terms of this agreement.

*Signature of Authorized Official _____ *Date _____

Provider Number

Street Address Line 2

*City
*State
*Zip Code + Four (Last 4 digits required)

North Carolina Department of Health and Human Services/Division of Medical Assistance	
Authorized Representative	Title
Date	



North Carolina Department of Health and Human Services

Division of Medical Assistance

HEALTH CHECK AGREEMENT BETWEEN PRIMARY CARE PROVIDER (PCP) AND THE LOCAL HEALTH DEPARTMENT

For recipients of Medicaid, birth to age 21, the Health Check Medical Screening Exam is required as a comprehensive preventive service at age appropriate intervals. There are numerous components of the health check exam, all of which are required in the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in the attached document "Health Check Screening Components."

WHAT IS AN AGREEMENT FOR HEALTH CHECK?

If a Carolina ACCESS PCP cannot or chooses not to perform the comprehensive health check screenings, this agreement allows the PCP to contract with the Health Department serving the PCP's county to perform the screenings for enrollees in the birth to 21 year age group.

The agreement requires the following:

- The Health Department must provide the results of the exam to the PCP within 30 days unless follow-up is necessary, in which case, the Health Department must communicate the results of the screening within 24 hours.
- The PCP is required to coordinate any necessary treatment or follow-up care as determined by the screening.
- Under this agreement, the health department must perform all health check components at the time of the appointment unless circumstances require an appointment be rescheduled.

If the PCP chooses to utilize this agreement in order to meet this Carolina ACCESS requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the Director of the Health Department or an authorized representative must be submitted to the CSC EVC Center. The PCP must keep a copy of this agreement on file.

This agreement can be entered into or terminated at any time by the PCP or the Health Department. The CSC EVC Center must be notified immediately of any change in the status of the agreement.

Questions regarding this agreement or health check requirements can be made to Community Care of North Carolina-Carolina ACCESS (CCNC-CA) Customer Service Call Center at (919) 855-4780.

In order to provide coordinated care to those children who are enrolled in Carolina ACCESS and obtain primary care services from _____ and Health Check services and immunizations from _____ County Health Department (CHD), the undersigned agree to the following provisions.

Primary Care Provider agrees to:

1. Refer Carolina ACCESS patients to the CHD for Health Check appointments. If the patient is in the office, the physician/office staff will assist the patient in making a Health Check appointment with the CHD.
2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the patient's permanent record.
3. Monitor the information provided by the CHD to assure that children in the Carolina ACCESS program are receiving immunizations as scheduled and counsel patients appropriately if they are noncompliant with well child visits or immunizations.
4. Review information provided by the CHD and follow up with patients when additional services are needed.
5. Provide the Division of Medical Assistance Managed Care Section or its agents, at least thirty (30) days advance notice if the Primary Care Provider (PCP) and/or the CHD wishes to discontinue this Agreement.

The Health Department agrees to:

1. Provide age appropriate Health Check examinations and immunizations within ninety (90) days of the request for patients who are referred by the PCP or are self-referred.
2. Send Health Check physical examination and immunization records monthly to the Primary Care Provider.
3. Notify the Primary Care Provider of significant findings on the Health Check examination within twenty-four (24) hours. Allow the Primary Care Provider to direct further referrals for specialized testing or treatment.
4. Provide the Division of Medical Assistance Managed Care Section or its agents, thirty (30) days advance notice if the Primary Care Provider and/or the CHD wishes to discontinue this Agreement.

*Signature of Primary Care Provider (PCP) of Authorized Official

*Date

*Printed Name of Primary Care Provider or Authorized Official

PCP Medicaid Provider Number

Provider Group Name (if applicable)

*Signature of Health Department Director/Designee

*Date

*Printed Name of Health Department Director/Designee

*Health Department Medicaid Provider Number

cc: DMA CCNC, Assistant Director



North Carolina Department of Health and Human Services

Division of Medical Assistance

CAROLINA ACCESS HOSPITAL ADMITTING REQUIREMENT

The establishment of a continuous and comprehensive patient/provider relationship is an essential component of Carolina ACCESS. Therefore, Carolina ACCESS (CA) primary care providers (PCPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addresses the needs all enrollees or potential enrollees. If the CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the *Carolina ACCESS Hospital Admitting Agreement* form must be submitted to the CSC EVC Center to address this requirement for participation. To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the *Carolina ACCESS Hospital Admitting Agreement* form, which serves as the written agreement between the two parties. IF the Carolina ACCESS provider has entered into a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the application for participation or when a change occurs regarding the provider's management of inpatient hospital admissions.

Note: A *formal arrangement* is defined as a voluntary agreement between the Carolina ACCESS primary care provider and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Carolina ACCESS enrollee throughout the inpatient stay.

The following Carolina ACCESS requirements regarding inpatient hospital care must be met:

1. Under the conditions stated above, the CA PCP must provide inpatient hospital care, or have a signed *Carolina ACCESS Hospital Admitting Agreement* form on file at DMA or its agents.
2. All ages of the provider's CA enrollees or potential enrollees must be covered by the inpatient hospital care or formal arrangement for inpatient hospital care or a combination of the two.
3. If the *Carolina ACCESS Hospital Admitting Agreement* form is utilized, the Agreement(s) must be between the CA PCP and one or more of the following:
 - a physician
 - a group practice
 - a hospitalist group
 - a physician call group

Note: The above providers must be enrolled as NC Medicaid providers, but it is not necessary that they be enrolled as Carolina ACCESS providers. Admissions through unassigned hospital-based call groups do not meet this requirement.

4. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes drive time from the CA PCP's practice.

Note: If there is no hospital that meets the above geographical criteria, *the hospital geographically closest to the CA PCP's (Contractor's) practice will be accepted.*

5. Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

Note: For more information refer to the *Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program*, Section IV, 6.4.

Questions regarding hospital admitting privileges may be directed to Community Care of North Carolina-Carolina ACCESS (CCNC-CA) Customer Service Call Center by calling 919-855-4780.

If you have any questions or need additional information, please feel free to contact NC Medicaid Provider Enrollment at the CSC EVC Center at 866-844-1113 or email the CSC EVC Center at NCMedicaid@csc.com.

For additional information, refer to the NC Medicaid Provider Enrollment web page – <http://www.nctracks.nc.gov> or the N.C. Division of Medical Assistance Home Page - <http://www.ncdhhs.gov/dma>.



North Carolina Department of Health and Human Services
Division of Medical Assistance
CAROLINA ACCESS HOSPITAL ADMITTING
AGREEMENT/FORMAL ARRANGEMENT

This form is to be completed only if the Carolina ACCESS (CA) Primary Care Provider (PCP) does not provide inpatient hospital care that addresses the needs of the CA enrollees or potential enrollees.

Carolina ACCESS Primary Care Provider or Applicant
(First Party Section)

*CA PCP Name Medicaid Provider Number

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City *State *Zip Code + Four (Last 4 digits required)

*Contact Person *Telephone Number (including area code)

To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form. This form serves as a formal written agreement established between the two parties as follows:

- The Carolina ACCESS Primary Care Provider is privileged to refer Carolina ACCESS patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The second party will arrange coverage for Carolina ACCESS enrollee admissions during their vacations.
- Either party may terminate this agreement at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The Carolina ACCESS Primary Care Provider will notify Carolina ACCESS in writing of any changes to or terminations of this agreement.

- The Carolina ACCESS Primary Care Provider will provide the second party with the appropriate payment authorization number.

**Physician and/or Group Agreeing to Cover Hospital Admissions for Above Carolina
ACCESS Primary Care Provider or Applicant**
(Second Party Section)

*Physician/Group Name	Medicaid Provider Number
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*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City	*State	*Zip Code + Four (Last 4 digits required)
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*Specialty	*Ages Admitted
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*Hospital Affiliation(s) and Location(s)

*Contact Person	*Telephone Number (including area code)
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*Authorized Signature	*Date
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North Carolina Department of Health and Human Services

Division of Medical Assistance

PROVIDER CONFIDENTIAL INFORMATION AND SECURITY AGREEMENT INSTRUCTIONS

Attention: Carolina ACCESS Primary Care Providers

Carolina ACCESS Enrollment, Referral, Emergency Room, and Utilization Reports

The Division of Medical Assistance's Managed Care Section is beginning the process of replacing paper copies of the Carolina ACCESS Enrollment, Referral, Emergency Room, and Quarterly Utilization reports with web-based versions of the reports. Each Carolina ACCESS Primary Care Provider (PCP) must complete the Provider Confidential Information and Security Agreement and return it to gain access to these web-based versions. Each approved user will receive log in information via email. This e-mail will include a link to the DMA Information and Report System <http://reports.ncmedicaid.com> where the user will have access to the following:

- Security Contact Administration
- On-line training
- Access to View Reports
- Technical Support
- Additional Information (related sites)

Instructions for Completing the Provider Confidential Information and Security Agreement

Only one Provider Confidential Information and Security Agreement shall be active for each enrolled Carolina ACCESS Primary Care Provider. If a practice is enrolled as a group, the practice must select one person as the Security Contact for the group. Likewise, if individual providers in a group practice have chosen to enroll with Carolina ACCESS individually, a Provider Confidential Information and Security Agreement must be completed for each individual provider enrolled. Providers MAY choose to select ONE Security Contact person for multiple practices or for more than one Carolina ACCESS provider number, but a form containing original signatures must be submitted for each active Carolina ACCESS provider number. The Security Contact person will be given the ability to add other users in the practice or network to the system so that they can access reports. The provider is responsible for the oversight of the Security Contact person's role.

1. Carolina ACCESS Practice Provider's Enrollment Number:

The provider number on the Provider Confidential Information and Security Agreement must be the active Carolina ACCESS provider number because it drives the separation of the reports. Some of these reports include private health information (PHI) and are covered under the HIPPA Privacy Act for the patients listed on the reports. It is very important that a user is not granted access to a Provider Number he or she has not been approved access.

2. Carolina ACCESS Practice Name:

Because the Carolina ACCESS practice name is used for verification when approving a user access to provider reports, it is important to list the practice name as it appears on the Carolina ACCESS application.

3. Carolina ACCESS Practice Address:

The Carolina ACCESS practice address is also used for verification when approving a user access to Provider reports and must agree with the information provided on the Carolina ACCESS application.

4. Provider's Security Contact Name (First, Middle, Last):

- a)** Security Contact Name must be printed clearly and listed exactly as it is listed on the Security Contact User's Social Security Card.
- b)** The Social Security Administration is working to develop a (Pass/Fail) one-time verification whose sole purpose is to match a user with a Social Security Number. This verification will not be used in any other manner. Private information related to the Social Security Number will not be accessible or stored in any way. User's Social Security Numbers will not be posted anywhere for State or Provider Access. This process has been created to assure the validity of all users who will access PHI reports.
- c)** Social Security Numbers will be linked to a user in a secure database on site. User names and Social Security Numbers will not be stored on any web site or shared servers. This process is being used to protect PHI system access as well as to protect the user.
- d)** There is a possibility of approximately 3,000 to 5,000 users involved in the Carolina Access Web Portal release. The Carolina Access Project is the first of many projects providing this type of information concerning PHI across the State of North Carolina.
- e)** This method of "identity management" (i.e., linking user name with SSN within a secure database) is extremely secure and reliable and is more assuredly in the best interest of both the State and the Provider.

5. Security Contact Birth Date:

Birth Date is additional information requires for Provider Employee distinction.

6. Provider's Security Contact Signature and Date:

The original signature of the designated Security Contact person and date are required to keep on file for Security and Federal audits.

7. Provider Security Contact Person's Social Security Number:

Please see number (4) above. The User is protecting the practice by providing us with this information. With this information, we can assure that unauthorized access to the provider's reports and to patient PHI is eliminated. Accessing PHI via a Web Portal is a great step towards future Health Care if done so in a secure environment.

Because sending passwords via e-mail is against HIPPA Security Rules, the Security Contact person will receive an e-mail containing the assigned user ID a message that the initial temporary password is the Security Contact person's social security number. At initial login, the user will be forced to change their password for additional security. DMA grants the Security Contact access to the appropriate provider reports and no one else sees the user's SSN.

8. Provider Security Contact Person's e-mail:

We require an e-mail address so the Security Contact Person will be able to receive the log on information. If a Provider has internet access in the office, the user could set up an address to be used only for work-related purposes. In the future, the total DMA Information and Report System users could reach the tens of thousands and the State must make this process as electronic as possible. Once the user has been approved and access given, they will receive an email with information about the DMA Information and Report System and a link to this portal.

9. Provider Witness of Security Contact Signature and Date:

The actual signature of the Carolina ACCESS Primary Care Provider and date signed is required to verify the provider has authorized this user to access the provider's reports. The signature must be that of an active Carolina ACCESS PCP listed on the Carolina ACCESS application for the corresponding practice and Carolina ACCESS provider number. This signature also authorizes the Security Contact person to set up or modify access of other users in the office. The appropriate signature is required for State and Federal Audits.

10. DMA Sponsor and Date (DHHS OFFICE USE ONLY):

The DMA Sponsor who approves the Carolina ACCESS Contract or change in Provider Security Contact Person is required to sign and date on this line for State and Federal Audits.



North Carolina Department of Health and Human Services
Division of Medical Assistance
PROVIDER CONFIDENTIAL INFORMATION AND SECURITY
AGREEMENT

The Provider understands that:

The identity of Medicaid applicants and recipients including, but not limited to, Medicaid identification numbers, names, and related medical health claim information is confidential protected health information and may only be disclosed in accordance with DHHS, state, and federal laws and regulations.

Each provider must delegate a staff member as the Security Contact Person who will be responsible for requesting user access to automated reports and resources. The Security Contact Person or Provider must also notify the Division of Medical Assistance (DMA) of any change in job duties, termination of employment, or leave of absence that would require immediate action for a user.

All passwords assigned to the provider and designated users for access to automated reports and resources are confidential. Logon identifiers and passwords uniquely identify the user. It is a violation of federal and state laws and regulations and the Department of Health and Human Services and DMA system security policy to divulge or share logon identifiers and passwords with another person.

To protect confidential data, the provider and designated users must safeguard and protect electronic data transactions that transmit protected health information about Medicaid applicants and recipients. The provider and designated users are responsible for ensuring that reasonable efforts must be made to protect the confidentiality of individually identifiable health information in all situations including e-mail, regular mail, fax, etc. All users with approved access to multiple Provider reports are responsible for accessing the data at the location specified by the approving provider.

DMA or its agents, will retain this original signed Agreement in the provider's file. Providers should copy and retain a copy of this agreement in their files.

The signature of the designated Provider Security Contact person and the Provider witness signifies that the Provider and the Security Contact person have read this Agreement and understand the obligations to protect confidential protected health information. The Provider further agrees that the rules and regulations pertaining to privacy and security mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 P.L. 104-91, as amended apply to the terms of this agreement and any agreements or practices executed by DMA or its agents to comply with HIPAA requirements.

Provider Confidential Information and Security Agreement

☐ Check if this is a change for your Designated Security Contact

*Carolina ACCESS Practice NPI

Medicaid Provider Number

*Carolina ACCESS Practice Name

*Phone Number (including area code)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City

*State

*Zip Code + Four (Last 4 digits required)

*Signature of Provider's Security Contact

*Date

*Printed Name of Provider's Security Contact (Last, First, Middle)

*Security Contact Date of Birth

*Security Contact E-mail Address

*Security Contact Social Security Number

DMA Sponsor

Date